Utah Behavioral Health Planning and Advisory Council
Preliminary Meeting Minutes
April 4th, 2019, 12:00 p.m.
Multi-Agency State Office Building, Room 2026
195 N 1950 W, Salt Lake City

"Our mission is to ensure quality behavioral health care in Utah by promoting collaboration, advocacy, education, and delivery of services."

COUNCIL MEMBERS PRESENT: Ken Rosenbaum, Lisa Hancock, Lori Cerar, Rob Wesemann, Emily Bennett, Sigrid Nolte, Peggy Hostetter, Owen Ashton, James Park, Jeanine Park, Rafael Montero, Kim Gardiner, Jennifer Marchant, Dan Braun, Diana Aguilera, Andrew Riggle, Cathy Davis (remote), Jacob Russell (remote),

DSAMH STAFF PRESENT: Christine Simonette, Pam Bennett, Jeremy Christensen, Heidi Peterson (remote), Robert Snarr, and Heather Rydalch

OTHERS PRESENT: Adam Scherzinger, Ryan Hunsaker, Kylee Porter, Nettie Byrne

COUNCIL MEMBERS EXCUSED: Ron Bruno, MaryJo McMillen, Shanel Long, Cyndie Moore, Jane Lepisto, Dave Wilde, Don Cleveland

Welcome, Introductions, March meeting minutes review, new member applications, and announcements:

Owen began the meeting and introductions were made around the room.

The new member applications for Ryan Hunsaker and Adam Scherzinger were approved by the Executive Committee and Owen asked the Council for a motion to approve. Jeanine made a 1st motion, Lisa made a 2nd motion, all were in favor and the applications for Adam and Ryan were approved. Welcome to UBHPAC Adam and Ryan!

Owen asked for a motion to approve the minutes from March. Jeanine made a 1st motion to approve the minutes, Ken made a 2nd, all were in favor and the motion passed unanimously.

The Executive Committee has proposed having two members per meeting take a few minutes to share some information about themselves and why they are invested in UBHPAC at each meeting. The Council agreed to participate and Nettie will reach out to two people from the member list before each meeting to ask them to share.

The 2019 Peer Conference will be held June 7th at the Karen Gail Miller Conference Center, 9750 South 300 West, Sandy, UT 84070. To register go to https://www.eventbrite.com/e/2019-utah-peer-conference-recovery-works-fired-up-for-wellness-tickets-60350487934.

The next NAMI walk will be on Sat, May 4, 10am – 12pm, Veterans Memorial Park, 1985 W 7800 S, West Jordan, UT 84088. Visit https://www.namiut.org/news-and-events/nami-walks to register or donate.

AUCH is hosting Trauma Informed Supervision training on Thursday & Friday, April 25-26, 2nd Floor Conference Room | 860 E. 4500 S. Salt Lake City, Utah. Cost: Non-Members $200; Members $150. To register visit https://auch.org/training-events/training-and-event-calendar/clinical/668-trauma-informed-supervision.

Rob Wesemann has agreed to serve as the Council interim co-chair. Jeanine made a 1st motion to approve, Andrew made the 2nd motion, all were in favor and motion passed unanimously. The UBHPAC Executive Committee will still work to identify potential co-chair candidates to ensure more involvement within the council.

MHBG FY19: Jeremy Christensen

Jeremy reviewed the FY19 Mental Health Block Grant budget. The funding chart is listed below and includes timelines, training contracts, prevention & early intervention, treatment, and recovery support.

Description	Start/End Dates	SFY20 Budget
Administration	Ongoing	302,592
Subtotal		**302,592**
Training Contracts		
State Mental Health Conference (Generations)	Ongoing	46,000
Other Conference sponsorships	Ongoing	43,850
Clubhouse Training Certification	ongoing	15,000
Crisis Intervention Training	7/1/16 - 6/30/21	31,300
Designated Examiner Training Seminar	Ongoing	1,700
LBHS Peer Support Conference	Ends 6/30/21	15,000
Peer Support Training	Ongoing	30,000
DLA-20 Training	Ends 6/30/20	21,000
Suicide Prevention Training for CPSS	Ongoing	30,000
Dual Diagnosis Training - NADD	Ends 6/30/20	25,000
Utah Quality Care Outcome Improvement Initiative	Initial Ends 6/30/20	100,000
Subtotal		**358,850**
Prevention and Early Intervention		
Mental Health Promotion / Mental Illness Prevention Services	Ongoing	347,400
Latino and other minority pilot	Ongoing	50,000
Family Resource Facilitators Statewide	Ongoing	182,415
Family Mentors	Ongoing	214,620
Mental Health Early Intervention Bridge	Ends 6/30/20	650,000
Disability Employment Media Campaign - UDDC	Ends 6/30/20	50,000
Screening For Mental Health	Ongoing	20,000
Subtotal		**1,514,435**

Treatment		
Adult Pass-through to Local Authorities	Ongoing	1,780,000
Children Pass-through to Local Authorities	Ongoing	521,000
Federal Early Intervention (10%+)	Ongoing	968,000
Unfunded Services Bridge	Ends 6/30/20	100,000
Children's Outplacement Safety Net	Ongoing	10,000
Psychiatric Consultation with Primary Care	Ends 6/30 25	75,000
Crisis Integration Pilot - SUCCESS	Ends 6/30/20	100,000
LGBTQ - Transgender Pilot	Ends 6/30/21	125,000
OQ - Outcome Questionnaire Services	Ongoing	77,564
Certified Peer Support Core Training	Ongoing	30,000
Certified Peer Support Enhancement Training	Ongoing	4,000
Subtotal		**3,790,564**
Recovery Support		
Consumer Advocate Statewide	Ongoing	93,300
UBHPAC Expense (Stipends and Facilitator Contract)	Ongoing	50,000
Subtotal		**143,300**
Miscellaneous		
Other Support Costs - Travel, Printing, Websites	Ongoing	94,900
SAMHIS Programming	Ongoing	16,000
Subtotal		**110,900**
Total		**6,220,641**

Primary Care Behavioral Health Integration- Dan Braun & Emily Bennett

What is integrated care?

"The care that results from a practice ***team*** of primary care and behavioral health clinicians, ***working together*** with patients and families, using a systematic and ***cost-effective*** approach to provide ***patient-centered care*** for ***a defined population***. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization."
Peek CJ and the National Integration Academy Council. Executive Summary – Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-1-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. http://integrationacademy.ahrq.gov

Why integrate in primary care?

- Primary care is a crucial part of well-functioning healthcare systems. Countries with the healthiest populations have the most robust PC services, which include behavioral health services.
- The traditional mental health system does not meet the needs of the population. While PCPs may refer to traditional mental health services, there are many barriers to patients accessing that system.
- PCPs report job dissatisfaction and recruitment is difficult, especially at Community Health Centers and in rural areas. Creating a robust PC Team reduces burn-out.

(Robinson, P. J., & Reiter, J. T. 2018)

- There may be stigma related to pursuing mental health services directly. In a fully integrated setting, there is no disclosure as to what the patient is receiving services for.
- Primary Care has become the main point of access to care for all healthcare, including behavioral health conditions.
    - *Up to 70% of primary care medical appointments are for problems stemming from psychosocial issues (Gatchel & Oordt, 2003).*
    - *Central stage for the complex and bidirectional interplay between medical and mental health disorders, health behaviors, and social determinants of health*

The Adverse Childhood Experiences Study (ACE Study) was a groundbreaking research study conducted by Kaiser Permanente and the Centers for Disease Control and Prevention (CDC). It was the first large scale study to look at the relationship between ten categories of adversity in childhood and health outcomes in adulthood.

This, and subsequent research, shows that the adversity we experience as a child can affect how our stress response functions, leading to long-term changes in our brains and bodies and leading to health problems as an adult.

ACES increase possibility "in a strong and graded fashion" of significant health and social problems, including; substance use, depression, pulmonary and heart disease, fetal death, early sexual activity, STD's, smoking, suicide attempts, unintended pregnancies, and poor quality of life.

Integration Models-

Facilitated Referral:

Primary care setting screens and uncovers BH issues, then facilitates appropriate referral to specialty BH setting.

- *Coordination of care is essential to share perspective and expertise. Patient follow through also increases with such.*
- *More viable for small organizations or those that plan to evolve toward more complex structures in the future.*
- *Includes medical home duties, Community Resource Database (CRD), and community collaboration.*

Co-location:

BH practitioners and primary care physicians (PCPs) work separately, yet at same location. Clinicians may or may not work for same organization.

- *"Traditional Therapy" (i.e. 45-60 min sessions) sessions are offered from in-house provider.*
- *Generally, serve patients with less serious BH conditions than specialty settings.*
- *Often traditional private practice therapy services.*

Full Integration:

Primary and BH services are incorporated into clinic flow, using brief interventions and consultations.

- *Warm handoffs, facilitated communication, team-based care, and fully shared charts.*
- *Traditional Therapy is typically not provided in clinic; instead sessions are brief, 15-30 min targeted encounters.*
- *Brief encounters are conducted by a Behavioral Health Consultant (BHC) who is a member of the Primary Care Team.*

PCP Referral for BHC Services

Mental Health Behavioral issues-

- Diagnostic clarification and intervention planning
- Facilitate consultation with psychiatry regarding psychotropic medications
- Behavior and mood management
- Suicidal/homicidal risk assessment
- Substance abuse assessment and intervention
- Panic/Anxiety management
- Interim check of psychotropic medication response
- Co-management of somaticizing patients
- Parenting skills
- Stress and anger management

Health Behavior/Disease Management

- Medication Adherence
- Weight Management
- Chronic Pain Management
- Smoking Cessation
- Insomnia / Sleep Hygiene
- Psychosocial and Behavioral Aspects of Chronic Disease
- Any Health Behavior Change
- Management of High Medical Utilization

Bottom line: Integration improves patient outcomes, reduces burden on PCPs, provides broader support to patients and their families within the primary care setting, and has researched fiscal benefits.

Subcommittee Reports:

Subcommittee meetings were not held.

Next meeting will be May 2nd 2019, 12:00 P.M.

Thank you for your support of the UBHPAC!

Accommodations to the known disabilities of individuals in compliance with the Americans with Disabilities Act. For accommodation information or if you need special accommodations during this meeting, please contact the Division of Substance Abuse and Mental Health at (801) 538-3939 or TTY (801) 538-3696.

The State has adopted a stipend policy that will pay for reasonable travel expenses related to consumers and advocates attendance at UBHPAC meetings. For more information please visit www.dsamh.utah.gov – Initiatives – Behavioral Health and Advisory Council – Information & Forms – UBHPAC Stipend Policy.

All meeting minutes and recordings are posted on the Public Notice website at:
https://www.utah.gov/pmn/sitemap/publicbody/51.html